Department of Workforce Development
Worker's Compensation Division
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Madison, WI 53707-7901
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http://dwd.wisconsin.gov/wc
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COMPROMISE AGREEMENT

Notice: To expedite processing of compromises, provide current addresses of all parties involved.

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m), Wisconsin Statutes].

WC Claim Number	Employee Name	Employee Birth Date
Employee Social Security Number*	Employee Mailing Address (number, street, city, state, zip code)	
Date of Alleged Injury	Employer Name	Employer Address (number, street, city, state, zip code)
Insurance Company Name	Insurance Company Address (number, street, city, state, zip code)	

It is ☐ disputed ☐ undisputed that the employee was employed by the respondent employer

Employee Earned Weekly Wage of **$**	Compensation Previously Paid Is **$**

The conceded disability is:

There is a bona fide dispute between the parties as to whether the employee:

Therefore the parties, subject to the approval of the Department of Workforce Development, agree to a Compromise Settlement as follows:

NOTICE TO EMPLOYEE: **The employee has the right to petition the Department of Workforce Development to set aside or modify this compromise agreement within one year of its approval by the department. The department may set aside or modify the compromise agreement. The right to request the department to set aside or modify the compromise agreement does not guarantee that the compromise will in fact be reopened.**

Employee Signature and Date Signed:	Witness Signature and Date Signed
Employee Attorney Signature and Date Signed:	Self-Insured Employer or Insurance Carrier Signature and Date Signed:

Date of Agreement:	**Attorney Fee:** _________	**Percent**	**List:**
	Protect: ______________	☐ **Yes** ☐ **No**	
	Costs:	☐ **Yes** ☐ **No**	